Health Impact on Lives: Health and Quality Improvement Committee

Minutes

Meeting Information			
Date	Thursday, September 26, 2019	**Time**	3:00 – 4:30 PM
Location	**303 E 17th Avenue, 11th Floor, 11C**	**Call-in Number**	1-877-820-7831 // 946029#
Webinar Link	https://cohcpf.adobeconnect.com/hiol/		
Committee Purpose	Discuss best practices and challenges to improving quality and health outcomes for ACC members and make recommendations for the ACC PIAC and the Department with regard to quality.		
Meeting Purpose	Review RAE performance on the Key Performance Indicators (KPIs), discuss timeline for Health Impact on Lives subcommittee involvement in revised KPIs and RAE deliverable process, provide an update on member engagement discussions with the Department, and review previous committee recommendations to the Department.		

Meeting Attendance
Voting Members and Participants
Morgan Anderson, Deb Barnette, Emily Berry, Megan Comer, Samantha Fields, Angela Goodjer, Ben Harris, Kathryn Jantz, David Keller, Russell Kennedy, Cathy Michopoulos, Gary Montrose, Isabelle Nathanson, Valerie Nielson, Tony Olimpio, Bethany Pray, Julie Reiskin, Kevin Ross

Speaker(s)	Description
DK, BP and Dept staff	Roll call and August minutes approved, one abstention.
All	**Review of RAE KPI performance data** ***KPI methodology can be found here.** The group reviews and discusses Quarter 1 and Quarter 2 key performance indicator (KPI) data from fiscal year 2018-2019. Quarter 3 data from the fiscal year will be available soon. • Per Kim Bimestefer's presentation to the Program Improvement Advisory Committee (PIAC) in August, Ben Harris from HCPF confirms the Department is taking a closer look at KPIs to assess where points of improvement can be made. • Additionally, alternative payment model (APM) workgroups will begin in October; the Department is considering updates to the APM measure set for 2020. Most of the current measures will remain for 2020, new measures may be added based on feedback, and measures that are not widely used or have been discontinued may be removed. • Quarter 2 data examined in this meeting is from fall 2018 and RAEs have recently been paid out for these measures. This timeline gives a sense of the lag. • Examining this data may lead to a recommendation to be taken to PIAC. • The committee requests more information regarding how quickly the RAEs get feedback on their KPIs from each quarter. Emergency Department Utilization • For this measure, a negative number is good.

	• This is a 12-month rolling measure due to the seasonality of ER use (summer of this year to summer of last year). HCPF to follow-up/confirm. • RAE 2 and RAE 4 both decreased from Q1 to Q2, RAE 4 most notably. • Group notes that having numbers along with rate would be helpful as they would give more context of where the RAE is starting with the measure. Matt Lanphier at the Department is working on a way to best display this information in a public setting, so that this kind of context is clear. • This KPI is the only measure that is risk-adjusted. Ben notes that the Department can keep this in mind as refinements are being made. • Utilization rates are different for adults and children. • Group discusses the possibility of overlaying data on ERs per capita, especially advertisement information, with this utilization data. ○ Unclear on availability of that data. • Possibility of sorting claims data by geography to find hot spots with access barriers. • Discussion is working off assumption that ERs are over-utilized. • Flag to calculate behavioral health-only visits. Additionally, questions are raised about if someone is admitted to the ER for alcohol poisoning or a suicide attempt, is that data something to capture? • Overall consensus: the group is interested in what the rate is as well as the degree of change over time. The group is also interested in the Department's thought on there being a lower limit of ED utilization. Is there a risk of depriving people of the ED, and do we need a balancing measure? Health Neighborhood Pt. 1, Health Neighborhood Pt. 2 • Part 1 of the data is in reference to care compacts. • RAE 1 noticeable performance with care compacts. A representative from RAE 1 confirms this is something they prioritize with all of their practices. • One concern is that this data does not show the depth of the relationship; typically, these are paper contracts between the two parties. • Concern of corporate-owned practices and their agency to decide if/how many Medicaid patients they can take. • Health Neighborhood pt. 2 data is in reference to percentage of sub-specialty visits. Proximity of sub-specialty clinics to primary care will affect this. • Confusing that this particular measure has both positive and negative results, the Department can follow-up on an explanation for this. • Opinion of some group members that this be one of the KPIs that gets reworked. The intention of the measure has been lost in that the care compact has become a check box instead of a conversation. • There are physician networks that do not have an understanding of the intent of the measure. • Discussion around putting responsibility with primary care to close the referral loop – challenge is that would require chart audits or an EHR that will capture that data. • Discussion of practices along the integration continuum, what would the data look like for a practice that provides both behavioral and physical health care.

	• The care compacts are would be a good place to get non-integrated primary care practices and behavioral health providers in the same room; learning collaboratives would be useful. • Ben notes the measure arose out the work done by the RCCOs, as they were, at the time, the mechanism to stitch these networks together. • The group is mindful of the administrative burden on practices, and also notes there is not a claims-based measure that gets at this information. • Overall consensus that this measure is valuable; the relationship between primary and specialty care is necessary. The connection needs to happen and the loop needs to be closed. • Department thinking through how to mechanize that process. • Dr. Keller recommends using measures validated by the National Quality Forum. ○ Dr. Keller offers to invite University of Colorado colleague to talk about NQF measure suite that may be of interest to this group. The group is interested. Behavioral Health Engagement • In quarter 1, all RAEs reached the tier I or tier II target. • Discussion follows around if the bar was set too low, and questions of assessing the quality of the services. • A greater percentage of people are accessing quarter over quarter, but all the measure reveals is that the service has been billed. • Group discussion about what is the goal of this measure; there needs to be a focus on quality not just quantity. • Suggestion of outcomes measures as an option. • Need to not only look at who but what; what should count as engagement. • Originally chosen for KPI measure set because this was a systems level change. • RAEs 1, 3, 5, 6, and 7 all look comparable to Behavioral Health Organization trends (when BHOs were the structure). • Measure results indicate little to no disturbance (in this measure) during transition from BHO to RAE structure. • More in-depth discussion needed on what this measure means and what is engagement. • Note that in a performance measure structure, not all RAEs will "win". • Need to discuss what the changes are we want to see, and what it is that should be paid for. Dental • RAE 3 and 5 (Colorado Access) have increased. • The measure is preventative, these results are good news and show progress. • RAE 2 shows improvement. • Overall, increase over previous quarter shows change in the right direction. Prenatal Engagement • By the numbers the RAEs are doing well but the rate of low birth weight by RAE is not changing. • Discussion to look at outcome in this case; having premature babies is a high cost. • Surprising that low birth weight rates are going up although prenatal engagement has increased. • Demography data would be helpful with this measure. • This measure presents a lot of opportunity for fine tuning.

	• Among members, it is difficult to figure out who is pregnant. That feels like a moving target, but the RAEs are continuing to work on it. • Unless the RAE has vigorous outreach strategies, the patient needs to make first contact to indicate pregnancy. • Many instances where a member might not have Medicaid at the time they become pregnant. • There are a lot of community organizations that work toward this goal; there is a role for Healthy Communities in this work. • CCHA representative notes that CCHA has unique relationships with Healthy Communities to include data-sharing – this relationship is key. • Large jump noted between Q1 and Q2 for RAE 5 – an observation. ○ Possibility of reporting/data issue. Could be improper coding. Well Visits • For the most part, measure improving among all RAEs. • CCHA representative notes new CCHA texting campaign promoting well visits. Some results seen include increase in care coordination levels and increase in website traffic (website traffic quadrupled after campaign). • Ben notes that for certain populations well visits are not appropriate. For the quarter 3 report, the committee would be interested in looking at comments made today compared to the data. The committee is interested in formulating the comments in this meeting into recommendations. Ben notes that the revision of these KPIs will be a process, and RAEs will be engaged in this process as well. A lot of this work is connected to other parts of the ACC program and we are working to tie this to specific goals of the ACC. Committee notes the aspiration to see the reporting evolve into something that would show process and outcome measures, so the numbers could be understood at a deeper level.
BP	**Member engagement discussion update** Bethany Pray and Isabelle Nathanson present a letter recently submitted to the Department outlining suggestions to HCPF about member engagement in the RAEs. The letter was one product from a recently finished project organized by the Colorado Consumer Health Initiative, Colorado Center on Law & Policy, Colorado Cross-Disability Coalition. • The letter calls out the previously submitted recommendations from the Health Impact on Lives subcommittee regarding member engagement. • Member engagement as a transformative force for the RAEs, not just in member advisory committees (as not all members want to engage in a meeting forum). • Last PIAC included conversations about Member Experience Advisory Councils (MEACs) and what RAEs are doing outside of those forums. • In general, the more points of contact the RAE can provide to let members know they have legitimate decision-making power the better. • Interest in hearing from RAEs on what they are doing with member engagement to further refine recommendations. • This is an ongoing conversation.

	• The Department has met with the above listed organizations to discuss the recommendations in the letter, and took next steps to bring this letter to this HIOL subcommittee.
	• Discussion to continue turning the points in this letter into official recommendations from this subcommittee.
	  o The group envisions that recommendations in this letter could be tracked similarly to other recommendations the subcommittee has made, possibly using new recommendation tracker to close the feedback loop.
	  o Ben recommends bringing RAEs to this venue first and going from there.
	• Subcommittee notes MEACs/(Member Advisory Councils) MACs are up and running now (as opposed to six months ago); and also note that member engagement is much more than running a MEAC/MAC. The recommendations go beyond that.
	• Discussion around bringing RAEs in to talk about member engagement.
	• Discussion on involving the Provider and Consumer Experience subcommittee.
	• Idea to bring member leaders into the conversation as well.

Meeting Action Items					
Date Added	**Action No.**	**Owner**	**Description**	**Due Date**	**Date Closed**
9/26/2019	1	HCPF	Clarification on the emergency department utilization measure: The emergency department KPI is calculated as the percent change from the performance period (rolling 12 months w/ 3 month run out) to the baseline time period (SFY17-18). *Follow-up: The emergency department KPI is calculated as the percent change from the performance period (rolling 12 months w/ 3 month run out) to the baseline time period (SFY17-18).*		
9/26/2019	2	HCPF	Clarification on Health Neighborhood measure; Department to follow-up on why this particular measure has both positive and negative results. *Follow-up: Negative numbers indicate the RAE is performing worse relative to their baseline performance, whereas the positive numbers indicate they are performing better relative to the baseline. For example if RAE 1 has -13.78%, it means their quarterly performance for that metric was a 13.78% regression from the baseline, for lack of a better phrase, whereas a positive number of 13.78% would indicate a 13.78% improvement from the baseline.*		
9/26/2019	3	HCPF/HIOL chairs	Dr. Keller offers to invite University of Colorado colleague to talk about NQF measure suite that may be of interest to this group.		

Reasonable accommodations will be provided upon request for persons with disabilities. Please notify Morgan Anderson at 303-866-2362 or morgan.anderson@state.co.us or the 504/ADA Coordinator hcpf504ada@state.co.us at least one week prior to the meeting to make arrangements.